EXHIBIT F

Robert Brigantic

From: JORGE IVAN MOSCOSO [jimassociatescorp@gmail.com]
Sent: Tuesday, December 24, 2019 1:50 PM
To: Robert Brigantic
Subject: stalin reyes
Attachments: 1st proposal .pdf; 1st report.pdf; Employers statement of wage earnings.pdf; final invoice - certificate of insurance.pdf; stucco invoice .pdf; workers compensation report.pdf

Robert here is the paperwork you needed please revise and contact me if everything is okay
--
Regards,

Jorge Moscoso - President

JIM ASSOCIATES CORP.
21-57 42TH STREET
ASTORIA, NY 11105
Tel:646-296-7757
jimassociatescorp@gmail.com

Gmail

JORGE IVAN MOSCOSO <jimassociatescorp@gmail.com>

(no subject)

2 messages

JORGE IVAN MOSCOSO <jimassociatescorp@gmail.com>
To: David Kleeman <Dkleeman@askelectric.com>

Tue, Jul 16, 2019 at 4:20 PM

David this sheet is per all extras

--
Regards,

Jorge Moscoso - President

JIM ASSOCIATES CORP.

JIM ASSOCIATES CORP.
21-57 42TH STREET
ASTORIA, NY 11105
Tel:646-296-7757
jimassociatescorp@gmail.com

Ask officee extras.pdf
692K

JORGE IVAN MOSCOSO <jimassociatescorp@gmail.com>
To: David Kleeman <Dkleeman@askelectric.com>

Thu, Jul 18, 2019 at 6:48 PM

David.
Here is the breakdown as requested. Everything is labor and material together
[Quoted text hidden]

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693K

PROPOSAL

JIM ASSOCIATES CORP.
21-57 42TH STREET BSMNT
ASTORIA,NY 11105
jimassociatescorp@gmail.com

DATE:	**July 18, 2019**
PREPARED BY:	Moscoso Jorge
CONTRACT / P.O. #	

CUSTOMER:	ASK Electrical Corp
PROJECT NAME:	New Office
ADDRESS:	217-14 Hempstead av Queens Village,NY 11429
CONTACT:	David Kleeman

Jim Associates Corp. proposes to provide all necessary labor, materials, tools, and equipment to complete :the renovation at above referenced project as per site survey and/or specifications for the following prices

Description	Amount
Scope-	
Build closet above stairs to basement with doors	$ 1,450.00
Build closet for electrical box by main entrance w/door	$ 2,000.00
Patch AC openings	$ 1,000.00
Remove drywall,install plywood blocking in conference room back wall. Patch and seal	$ 750.00
Furnish and install #6 Access doors throughout	$ 1,300.00
Furnish and install #3 alluminium saddle.	$ 420.00
Fill in gate frame for alliminium installation	$ 150.00
Dig out and remove dirt from underneath basement stairs	$ 900.00
Install 150 sf floor tile in basement room	$ 1,600.00
Build bench in basement	$ 1,500.00
152 sf of subway tile installation (Additional per 1st proposal)	$760
Install 18 sf kitchen backsplash	$ 90.00
Install kitchen cabinets ONLY	$ 1,200.00
Remove wonderboard in presidential bathroom shim and reinstall tape (For shower led)	$ 300.00
Install 132SF wood floor in conference room (Installation ONLY)	$ 2,985.00
Install 265SF wood floor in presidential room (Installation ONLY)	
Patch ceilings after plumbing and electric trades finish	$ 300.00
Open 2 small bathrooms install plywood blocking patch, and spakle	$ 300.00
Path basement ceiling corners from wall to ceiling	$ 300.00
box with pine around basement door to cover cables	$ 300.00
Prehung,cut as required and install wood doors after finish floor	$ 600.00
Install 560 LF ofbase molding (Installation only)	$ 1,500.00
Complete protection for finish flooring	$ 1,900.00
Square 2 doors openings . install new corner beats and spakle	$ 300.00
Patch and seal roof with flashing cement	$ 50.00
Deliver material to site	$ 300.00
SUBTOTAL	$ 22,255.00
OVERHEAD 15%	$ 3,338.00
	$ 25,593.00

We hereby accept the conditions of this proposal: You are authorized to commence work.

NYSIF New York State Insurance Fund

[7000-##########][373][15177-01][NEW-CLM--NCSLTR][01-00145]

JIM ASSOCIATES CORP.
21-57 42 STREET
ASTORIA NY 11105

07/18/2019

NYSIF Case Number: 72134075-373
Claimant: STALIN REYESESPINOZA

Policy Number: 2425098 - 7
Entity Number: 11
Date of Accident: 06/28/2019

Dear Employer:

Please note the information next to the box(es) checked below.

☒ Your First Report of Injury concerning the above captioned employee has been received. Please use the claim number listed above on all future correspondence regarding this matter.

☐ It has come to our attention that the above named employee may have incurred a work related injury/illness. To date, we have no record of receiving your completed First Report of Injury. Please be advised that an employer must file a First Report of Injury with NYSIF within ten (10) days of the employer's knowledge of a work-related injury/illness, provided that the injury/illness has caused or will cause the employee lost time from regular duties of one (1) day beyond the workday or shift during which the accident occurred; or has required or will require medical treatment beyond ordinary first aid or more than two (2) treatments by a person rendering first aid.

You may report all work related injuries/illnesses via NYSIF's eFROI reporting system, which can be accessed online at www.nysif.com by clicking on "Report an Injury", then "Report an Injury to NYSIF".

Please submit your report as soon as possible to facilitate the processing of the claim. If the claim is questionable or doubtful, please so indicate.

The employer must also provide an injured employee with a "Claimant Information Packet" at the time of injury or illness. This packet is available at www.nysif.com.

If we do not hear from you, it will be necessary for us to proceed in accordance with the Workers' Compensation Law and its rules and regulations, based on available information.

☐ NYSIF has received a medical bill for services rendered to the above named employee for an alleged injury or illness on the above accident date, while in the employ of your company. Unless NYSIF is notified to the contrary within ten (10) days, it will be presumed that the services billed were rendered as a result of an injury/illness that is confirmed by you as arising out of and in the course of employment, and the provider's bill will be processed for payment.

Respectfully Yours,
Nica Bradshaw
Case Manager
Phone: (212) 587-7397
Fax: (212)587-5438

00000000000072412791

NYSIF New York State Insurance Fund
199 CHURCH ST, NEW YORK, NY 10007-1100
(212) 587-7397

[7000-##########][373]

JIM ASSOCIATES CORP.
21-57 42 STREET
ASTORIA NY 11105

Claimant: REYESESPINOZA STALIN
Employer: JIM ASSOCIATES CORP.
21-57 42 STREET

NYSIF Claim No.: 72134075-373
WCB Claim No.: G2580210
Date of Accident: 06/28/2019

EMPLOYER'S REQUEST FOR REIMBURSEMENT

SEE INSTRUCTIONS ON BACK

To the Workers' Compensation Board:

The undersigned employer hereby requests FULL REIMBURSEMENT, in accordance with the Workers' Compensation Law, for wages advanced during a period of absence due to disability.

The total amount advanced was _____ dollars and

_____ cents ($_____)

for the period from _____ through _____

DATE _____

EMPLOYER'S REPRESENTATIVE:

Print Name _____

and Title _____

EMPLOYER'S SIGNATURE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

NOTE TO EMPLOYER:

Under current interpretations of Section 25 of the Workers' Compensation Law, in cases involving temporary disability, an employer may not recover more than the compensation benefit rate for the period during which compensation or wages were advanced, nor may there be any reimbursement for the first week if the disability does not exceed two (2) weeks.

CM: Nica Bradshaw

NYSIF New York State Insurance Fund
199 CHURCH ST, NEW YORK, NY 10007-1100
(212) 587-7397

[7000-##########][373]

JIM ASSOCIATES CORP.
21-57 42 STREET
ASTORIA NY 11105

Date: 07/17/2019

Claimant: REYESESPINOZA STALIN

NYSIF Claim No.: 72134075-373
WCB Claim No.: G2580210
Date of Accident: 06/28/2019

Dear Sir/Madam:

Kindly complete the enclosed forms C-11/C-240/C-107 in order to expedite processing of the captioned claim before the Workers' Compensation Board.

When you complete the C-240, if the injured employee worked for your firm for a minimum of 52 weeks prior to the injury, complete page 2 payroll table labeled "INJURED WORKER PAYROLL" with gross weekly earnings and number of days worked for the 52 weeks immediately preceding the injury date.

If the injured employee worked for your firm fewer than 52 weeks prior to the injury, complete the payroll table under the similar worker's First Name, Last Name and Title with payroll of an "EMPLOYEE of the SAME CLASS PAYROLL."

The first payroll table should detail gross weekly earnings of the injured employee during the term of his/her employment. The second payroll table should detail gross weekly earnings for an employee of the same class who has worked in the same or similar employment for 52 weeks prior to the date of the injured employee's accident.

All completed forms should be returned to the New York State Insurance Fund in the enclosed postage paid envelope.

Your immediate attention to this matter will be greatly appreciated.

Very truly yours,

Nica Bradshaw
Case Manager
Phone: (212) 587-7397

Instructions for Completing Employer's Statement of Wage Earnings (Form C-240)

CLAIM INFORMATION

Date of Injury/Illness: Enter the date the injured worker was injured or noticed they were ill. Enter the date in month/day/year format. Include the four digit year.
WCB Case #: The Workers' Compensation Board Case number.
Insurer Case #: The Claim Administrator Claim (Carrier Case) number.

INJURED WORKER INFORMATION

Last Name, First Name, MI: Enter the injured worker's full legal name.
Mailing Address: Enter the injured worker's full address, including PO Box, if applicable, city or town, state, zip code.
Social Security #: Enter the injured worker's Social Security Number.

INSURER INFORMATION

Insurer Name: Enter the name of the Workers' Compensation Insurer or Self-Insured Group name.
Mailing Address: Enter the insurer or claims administrator address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the insurer phone number, including area code and extension, if applicable.
Fax #: Enter the insurer fax number, including area code, if applicable.
Email Address: Enter the insurer or claims administrator email address.

EMPLOYER INFORMATION

Employer Name: Enter the name of the injured worker's employer.
Mailing Address: Enter the employer's full address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the employer phone number, including area code and extension, if applicable.
Federal Tax ID #: Enter the employer Federal Tax ID number.

1. **Payroll Information** - Indicate if payroll information is attached to this form or if the information is entered on page 2.
2. **Other Earnings**: If the injured worker received board, rent, housing, tips and/or other gratuities, provide the weekly value and describe the additional earnings. Note: Other earnings does not include accrued time such as vacation.
3. **Wage Information**: Enter the basis for injured worker's pay rate (hourly, daily, weekly, monthly or annually).
4. **Days Worked Per Week:** Check the number of days per week the injured worker's work schedule is based on. If it is other than a 5, 6 or 7 day week, explain.
5. **Total Days Paid**: Enter the total number of days for which the injured worker was paid in the 52 weeks immediately prior to the date of injury/illness, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7. Do not include accrued time such as vacation time.
6. **Total Gross Amount Paid Including Overtime:** Enter the injured worker's total gross pay (prior to taxes) for the 52 weeks immediately prior to the date of injury/illness, including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.
7. **Wage Adjustments**: If any wage adjustments (e.g., if the injured worker was demoted) were made during the 52 weeks prior to the injury/illness, explain. Advise if the injured worker was in military service during the 52 week period, and give date of discharge.
8. **Laid Off**: Indicate if the injured worker was laid off during the 52 week period immediately prior to the date of injury/illness, and provide the dates of layoff.

PREPARED BY

Last Name, First Name, MI: Enter the preparer's full legal name.
Employer Name: Enter the name of the preparer's employer.
Official Title: Enter the preparer's official title.
Phone #: Enter the preparer's phone number, including area code and extension, if applicable.
Email Address: Enter the preparer's email address.
Date of this Report: Enter the date this report was prepared.

INSTRUCTIONS FOR COMPLETING INJURED WORKER PAYROLL AND EMPLOYEE OF SAME CLASS PAYROLL

Injured Worker Payroll

Week Ending Date: Enter the week ending dates for each of the 52 weeks immediately prior to the date of injury/illness.
Days Compensated (including paid time off): In the "**Days Paid**" column, give the number of days worked in the employment for which the worker was paid, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7 on page 1. Do not include accrued time such as vacation time.
Gross Amount Paid including Overtime: Enter the injured worker's average weekly gross pay (prior to taxes), including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.

Employee of the Same Class Payroll: Give the gross weekly wages for an employee of the same class if the injured worker worked less than a substantial part of the year (234 days for a 5-day worker, or 270 days for a 6-day worker). In addition, provide name of employee in the same class and their job title. NOTE: "Number of days worked" is a guideline, and the Board may find that an injured worker has worked a substantial part of the year even if the injured worker did not work 234 days (5-day worker) or 270 days (6-day worker).

If attaching payroll information, do not submit page 2. All attachments should include the Injured Worker's full name, WCB Case # and Date of Injury/Illness.

Submit by mail or electronically directly to:

New York State Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Fax #: (877) 533-0337
WCB Address for Email Filing: wcbclaimsfiling@wcb.ny.gov
WCB Web Upload Link: https://wcbdoc.xrxfs.com/login.aspx

NYSIF
New York State Insurance Fund

P.O. Box 66699; Albany, NY 12206
212.587.7397 | **nysif.com**

[7000-############][373]

JIM ASSOCIATES CORP.
21-57 42 STREET
ASTORIA NY 11105

Date: 09/04/2019

Claimant: REYES-ESPINOZA STALIN

NYSIF Claim No.: 72134075-373
WCB Claim No.: G2580210
Date of Accident: 06/28/2019

Dear Sir/Madam:

Kindly complete the enclosed forms C-11/C-107/C-240 in order to expedite processing of the captioned claim before the Workers' Compensation Board.

When you complete the C-240, if the injured employee worked for your firm for a minimum of 52 weeks prior to the injury, complete page 2 payroll table labeled "INJURED WORKER PAYROLL" with gross weekly earnings and number of days worked for the 52 weeks immediately preceding the injury date.

If the injured employee worked for your firm fewer than 52 weeks prior to the injury, complete the payroll table under the similar worker's First Name, Last Name and Title with payroll of an "EMPLOYEE of the SAME CLASS PAYROLL."

The first payroll table should detail gross weekly earnings of the injured employee during the term of his/her employment. The second payroll table should detail gross weekly earnings for an employee of the same class who has worked in the same or similar employment for 52 weeks prior to the date of the injured employee's accident.

All completed forms should be returned to the New York State Insurance Fund in the enclosed postage paid envelope.

Your immediate attention to this matter will be greatly appreciated.

Sincerely,
Nica Bradshaw
Case Manager

INSTRUCTIONS

1. This form is used principally as evidence of a claim for reimbursement by an employer for monies advanced to a claimant on account of compensation due under the provisions of the Workers' Compensation Law.

2. Attention is drawn specifically to Section 25 of the Workers' Compensation Law, from which the following is extracted:

> "...If the employer has made advance payments of compensation, or has made payments to an employee in like manner as wages during any period of disability, he shall be entitled to be reimbursed out of an unpaid installment or installments of compensation due, provided his claim for reimbursement is filed before award of compensation is made, or, if insured, by the insurance carrier at the direction of the board, unless he shall file a waiver of reimbursement with the chairman, in which event compensation will be paid to the claimant notwithstanding the advance payments..."

3. It is recommended that, while payments are being advanced, this form be completed monthly and mailed to The Workers' Compensation Board. (See below).

A copy of this form should be sent to the New York State Insurance Fund.

Mailing Address for The Workers' Compensation Board

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

NYSIF New York State Insurance Fund
199 CHURCH ST, NEW YORK, NY 10007-1100 (212) 587-7397

[7000-##########][373]

JIM ASSOCIATES CORP.
21-57 42 STREET
ASTORIA NY 11105

Claimant: REYES-ESPINOZA STALIN
Employer: JIM ASSOCIATES CORP.
21-57 42 STREET

NYSIF Claim No.: 72134075-373
WCB Claim No.: G2580210
Date of Accident: 06/28/2019

EMPLOYER'S REQUEST FOR REIMBURSEMENT

SEE INSTRUCTIONS ON BACK

To the Workers' Compensation Board:

The undersigned employer hereby requests FULL REIMBURSEMENT, in accordance with the Workers' Compensation Law, for wages advanced during a period of absence due to disability.

The total amount advanced was _____ dollars and

_____ cents ($_____)

for the period from _____ through _____.

DATE: _____ EMPLOYER'S REPRESENTATIVE:

Print Name _____

and Title _____

EMPLOYER'S SIGNATURE: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

NOTE TO EMPLOYER:

Under current interpretations of Section 25 of the Workers' Compensation Law, in cases involving temporary disability, an employer may not recover more than the compensation benefit rate for the period during which compensation or wages were advanced, nor may there be any reimbursement for the first week if the disability does not exceed two (2) weeks.

CM: Nica Bradshaw 00000000000073936923

INSTRUCTIONS TO THE EMPLOYERS

Reports should be sent directly to the Workers' Compensation Board:

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Statewide Fax Line: 877-533-0337

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

C-11 (1-11) Reverse

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chair, Workers' Compensation Board at the address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2 or EC-2, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurance carrier.**

THE STATE INSURANCE FUND, 199 CHURCH ST, NEW YORK, NY 10007-1100

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS				
1. W.C.B. Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Claimant's Soc. Sec. No.
G2580210	72134075-373	W204002	06/28/2019	0

NAME		Address to which notice should be sent (Give Number and Street, City, State and Zip Code)	
6. Injured Person	REYES-ESPINOZA STALIN	151 AVE O 3B, BROOKLYN NY 11204	Apt.No.
7. Employer	JIM ASSOCIATES CORP.	21-57 42 STREET, ASTORIA, NY 11105	
8. Carrier	THE STATE INSURANCE FUND	199 CHURCH ST, NEW YORK, NY 10007-1100	

9. Date of most recent Employer's Report filed: (check "x" and give date filed) ☐ C-2/EC-2 _____ ☐ C-11/EC-11 _____

10. Date of first full day employee lost from work: _____ 11. Nature of Injury: _____

12. Date employee returned to work: _____

13. (a) Change of employment status resulting from above injury: _____

Employment Status	Hours per Day	Days per Week	Earnings per Week	Occupation
Prior To Injury				
Changed To				

(b) Date of this change in employment status: _____

(c) Remarks: _____

14. Loss of time resulting from above injury since first return to work:

From (mm/dd/yyyy)	To (mm/dd/yyyy)	Reason

15. Is injured person still under physician's care? _____ If yes, give name of physician: _____

16. Has injured person died? _____ If yes, give date of death: _____

Name and address of nearest known relative: _____

Date of this report _____ Tel. No. _____ Firm Name _____

Prepared By: _____ Official Title _____

CM: Nica Bradshaw 0000000000073936923

Form C-11 Version 1 (11/26/2013) [WC Loss ID-72134075]

www.wcb.ny.gov

Instructions for Completing Employer's Statement of Wage Earnings (Form C-240)

CLAIM INFORMATION

Date of Injury/Illness: Enter the date the injured worker was injured or noticed they were ill. Enter the date in month/day/year format. Include the four digit year.
WCB Case #: The Workers' Compensation Board Case number.
Insurer Case #: The Claim Administrator Claim (Carrier Case) number.

INJURED WORKER INFORMATION

Last Name, First Name, MI: Enter the injured worker's full legal name.
Mailing Address: Enter the injured worker's full address, including PO Box, if applicable, city or town, state, zip code.
Social Security #: Enter the injured worker's Social Security Number.

INSURER INFORMATION

Insurer Name: Enter the name of the Workers' Compensation Insurer or Self-Insured Group name.
Mailing Address: Enter the insurer or claims administrator address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the insurer phone number, including area code and extension, if applicable.
Fax #: Enter the insurer fax number, including area code, if applicable.
Email Address: Enter the insurer or claims administrator email address.

EMPLOYER INFORMATION

Employer Name: Enter the name of the injured worker's employer.
Mailing Address: Enter the employer's full address, including PO Box, if applicable, city or town, state, zip code.
Phone #: Enter the employer phone number, including area code and extension, if applicable.
Federal Tax ID #: Enter the employer Federal Tax ID number.

1. **Payroll Information** - Indicate if payroll information is attached to this form or if the information is entered on page 2.
2. **Other Earnings**: If the injured worker received board, rent, housing, tips and/or other gratuities, provide the weekly value and describe the additional earnings. Note: Other earnings does not include accrued time such as vacation.
3. **Wage Information**: Enter the basis for injured worker's pay rate (hourly, daily, weekly, monthly or annually).
4. **Days Worked Per Week:** Check the number of days per week the injured worker's work schedule is based on. If it is other than a 5, 6 or 7 day week, explain.
5. **Total Days Paid**: Enter the total number of days for which the injured worker was paid in the 52 weeks immediately prior to the date of injury/ illness, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7. Do not include accrued time such as vacation time.
6. **Total Gross Amount Paid Including Overtime:** Enter the injured worker's total gross pay (prior to taxes) for the 52 weeks immediately prior to the date of injury/illness, including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.
7. **Wage Adjustments**: If any wage adjustments (e.g., if the injured worker was demoted) were made during the 52 weeks prior to the injury/ illness, explain. Advise if the injured worker was in military service during the 52 week period, and give date of discharge.
8. **Laid Off**: Indicate if the injured worker was laid off during the 52 week period immediately prior to the date of injury/illness, and provide the dates of layoff.

PREPARED BY

Last Name, First Name, MI: Enter the preparer's full legal name.
Employer Name: Enter the name of the preparer's employer.
Official Title: Enter the preparer's official title.
Phone #: Enter the preparer's phone number, including area code and extension, if applicable.
Email Address: Enter the preparer's email address.
Date of this Report: Enter the date this report was prepared.

INSTRUCTIONS FOR COMPLETING INJURED WORKER PAYROLL AND EMPLOYEE OF SAME CLASS PAYROLL

Injured Worker Payroll

Week Ending Date: Enter the week ending dates for each of the 52 weeks immediately prior to the date of injury/illness.
Days Compensated (including paid time off): In the "**Days Paid**" column, give the number of days worked in the employment for which the worker was paid, including paid time off. If days paid (compensated) is zero, provide an explanation in question 7 on page 1. Do not include accrued time such as vacation time.
Gross Amount Paid including Overtime: Enter the injured worker's average weekly gross pay (prior to taxes), including overtime. Do not use the injured worker's take-home pay. "Wages" means the money rate at which the service rendered by the injured worker is compensated under the contract of hire in force at the time of the injury.

Employee of the Same Class Payroll: Give the gross weekly wages for an employee of the same class if the injured worker worked less than a substantial part of the year (234 days for a 5-day worker, or 270 days for a 6-day worker). In addition, provide name of employee in the same class and their job title. NOTE: "Number of days worked" is a guideline, and the Board may find that an injured worker has worked a substantial part of the year even if the injured worker did not work 234 days (5-day worker) or 270 days (6-day worker).

If attaching payroll information, do not submit page 2. All attachments should include the Injured Worker's full name, WCB Case # and Date of Injury/Illness.

Submit by mail or electronically directly to:

New York State Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Fax #: (877) 533-0337
WCB Address for Email Filing: wcbclaimsfiling@wcb.ny.gov
WCB Web Upload Link: https://wcbdoc.xrxfs.com/login.aspx

Injured Worker's Name: Stalin Reyes-Espinoza Date of Injury/Illness: 06/28/2019 WCB Case #: G2580210

INJURED WORKER PAYROLL Enter the injured worker's gross weekly earnings for the 52 weekly periods immediately preceding the date of injury/illness. In the "**Days Paid**" column enter the number of days compensated, including paid time off.

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

EMPLOYEE OF THE SAME CLASS PAYROLL. If the injured worker has not worked at the same employment for one year or a substantial part of the year, enter the gross weekly earnings for an employee of the same class. "Substantial part of the year" does not require any particular number of days worked, but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

Employee of the Same Class

First Name: Last Name: MI:

Job Title:

Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44			
9				27				45			
10				28				46			
11				29				47			
12				30				48			
13				31				49			
14				32				50			
15				33				51			
16				34				52			
17				35				Total:			
18				36							

NEW YORK STATE Workers' Compensation Board

EMPLOYER'S STATEMENT OF WAGE EARNINGS (Preceding the Date of Injury/Illness)

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: 06/28/2019 WCB Case #: G2580210 Claim Administrator Claim (Carrier Case) #: 72134075

Injured Worker Information

Last Name: Reyes-Espinoza First Name: Stalin MI:

Mailing Address: 151 Ave O Line 2:

City: BROOKLYN State: NY Zip Code: 11204

Job Title: WORKING ON THE FIELD Social Security #: 0

Insurer Information

Insurer Name: NEW YORK STATE INSURANCE FUND Insurer ID (W#): 204002

Mailing Address: 199 CHURCH ST Line 2:

City: NEW YORK State: NY Zip Code: 10007-1100

Insurer Phone #: (212)587-6568 Insurer Fax #: (212)312-0043 Email Address:

Employer Information

Employer Name: JIM ASSOCIATES CORP.

Mailing Address: 21-57 42 STREET Line 2:

City: ASTORIA State: NY Zip Code: 11105

Employer Phone #: 6462967757 Federal Tax ID #: The Tax ID # is the (check one): ☐ SSN ☐ EIN

To determine Average Weekly Wage (AWW), the Board needs the gross weekly earnings for the 52 weekly periods immediately preceding the date of the injury/illness. This information can be provided by 1) attaching detailed payroll information that indicates days paid and gross weekly earnings; 2) if injured worker is paid by salary and his or her weekly pay does not change from week-to-week, attach document(s) providing their salary information for the previous 52 weeks; or 3) by completing and submitting the **Injured Worker Payroll** section on page 2 of this form.

If the injured worker has not worked at the same employment for one year or a substantial part of the year, also attach detailed payroll information for an employee of the same class, or complete and submit the **Employee of the Same Class Payroll** section on page 2 of this form. "Substantial part of the year" does not require any particular number of days worked but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

1. Payroll information is: ☐ attached ☐ completed on page 2

2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐ Yes ☐ No

If Yes, what was the weekly value:

Nature of the compensation:

3. Basis for the injured worker pay rate is: ☐ hourly ☐ daily ☐ weekly ☐ monthly ☐ annually

4. The injured worker works a: ☐ 5 ☐ 6 ☐ 7 ☐ Other day week. If Other, Explain:

5. Total days paid in the preceding 52 weeks: 6. Total gross amount paid including overtime in the preceding 52 weeks:

7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No

If "Yes", explain:

8. Was the injured worker laid off during the preceding 52 weeks? ☐ Yes ☐ No

If Yes, provide dates of layoff :

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Prepared By - The above information is true and to the best of my knowledge and belief.

Last Name: First Name: MI:

Employer Name: ?

Official Title: ? Daytime Phone #:

Email Address: Date of this Report:

A.S.K Electrical Contracting Corp

EXHIBIT A
WORK ORDER FORM
NO.

Date: 07/15/2019

Project: 217-14 Hempstead Av, Queens Village NY 11429

Owner:

Dear :

("Contractor") would like ("Subcontractor") to perform certain construction services for the above identified Project in accordance with the scope of work as set forth below ("Work"). This Work Order is being issued in accordance with that certain Master Subcontract Agreement dated as entered into between Contractor and Subcontractor ("Master Agreement").

The Work must be completed in accordance with the following Project Schedule:

Compensation:

The Contractor shall pay the Subcontractor, subject to the terms of this Work Order, the liquidated sum of Dollars ($) inclusive of any and all Reimbursable Expenses.

Scope of Work:

The following Work is required to be performed pursuant to this Work Order:

Contract Documents:

The Contract Documents include the following:

SUBCONTRACTOR:

BY: Jorge Mascaro

NAME: JM Associates Corp

TITLE: President

DATE: 07/15/19

CONTRACTOR: ASK Electrical Contracting Corp.

BY: _____

NAME: David Kleeman

TITLE: President

DATE: _____

26-50 Brooklyn Queens Expy Unit 2 Woodside, NY 11377
Phone (718) 701-5758 Fax (718) 701-5912
www.askelectric.com

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/15/19

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
TRUST TAX & INSURANCE BROKERAGE INC
24-16 Sienway Street
Astoria, NY 11103

CONTACT NAME: TRUST TAX & INSURANCE BROKERAGE INC
PHONE (A/C, No, Ext): (718)956-2000 FAX (A/C, No): 718-956-2097
E-MAIL ADDRESS: trust_insurance@live.com

INSURED
JIM ASSOCIATES CORP
2157 42ST
BASEMENT
ASTORIA NY 11105

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : KINGSTONE INSURANCE COMPANY	
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 500,000.00
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000.00
				CP5019035	05/12/19	05/12/20	MED EXP (Any one person)	$ 5,000.00
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	$ 500,000.00
	X POLICY PRO-JECT LOC						GENERAL AGGREGATE	$ 500,000.00
	OTHER:						PRODUCTS - COMP/OP AGG	$ 500,000.00
	AUTOMOBILE LIABILITY							$
	ANY AUTO						COMBINED SINGLE LIMIT (Ea accident)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per person)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
	UMBRELLA LIAB / OCCUR							$
	EXCESS LIAB / CLAIMS-MADE						EACH OCCURRENCE	$
	DED / RETENTION $						AGGREGATE	$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N							$
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)		N / A				PER STATUTE / OTH-ER	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

ASK ELECTRICAL CONTRACTING CORP
26-50 BQE WEST UNIT 2
WOODSIDE,NY 11377

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ACORD 25 (2016/03)

Gmail david

Good afternoon just checking if You had finish revising invoices and returning them back to me.

David Kleeman
to Kavita, me

GM Jorge,

Were all set with the revised invoices if you would like to come in this week.... After Wednesday I will no

David Kleeman
Principal / M.E.
A.S.K Electrical Corp.
217-14 Hempstead Avenue
Queens Village, NY 11429

Phone: 718-701-5758
Fax: 718-701-5912
Email: dkleeman@askelectric.com
Web: www.askelectric.com

JORGE IVAN MOSCOSO <jimassociatescorp@gmail.com>
to David

Tomorrow is fine just let me know what time is best for you

JIM ASSOCIATES CORP.

Jim Associates Corp.

	Original Work	Change Orders	Total Amounts
Original Proposal - 06/12/19	32,256.00		32,256.00
Extras #1 - Proposal 7/18/19		25,593.00	
Credit Adjustment Extras #1		(9,948.00)	15,645.00
Extras #2 - Proposal 10/29/19		23,552.00	
Credit Adjustment Extras #2		(10,762.00)	12,790.00
Stucco - Proposal 09/03/19		2,200.00	2,200.00
		Total Contract	**62,891.00**

Total Contract		**62,891.00**
Payment - ck #1140	06/27/19	(12,000.00)
Payment - ck #1176	07/24/19	(15,000.00)
Payment - ck #1222	08/27/19	(20,849.00)
Final Amount Due		**15,042.00**

EXTRAS #1 - Proposal dated 07/18/19

Scope-	Original Amount	Adjustments	Final Amount
Build closet above stairs to basement with doors ($ 1,450.00)	1,450.00	(250.00)	1,200.00
Build closet for electrical box by main entrance w/door ($ 2,000.00)	2,000.00	(1,000.00)	1,000.00
Patch AC openings ($ 1,000.00)	1,000.00	-	1,000.00
Remove drywall,install plywood blocking in conference room back wall. Patch and seal ($ 750.00)	750.00	(250.00)	500.00
Furnish and install #6 Access doors throughout ($ 1,300.00)	1,300.00	(250.00)	1,050.00
Furnish and install #3 alluminium saddle. ($ 420.00)	420.00	-	420.00
Fill in gate frame for alliminium installation ($ 150.00)	150.00	(150.00)	-
Dig out and remove dirt from underneath basement stairs ($ 900.00)	900.00	(300.00)	600.00
Install 150 sf floor tile in basement room ($ 1,600.00)	1,600.00	(200.00)	1,400.00
Build bench in basement ($ 1,500.00)	1,500.00	(500.00)	1,000.00
152 sf of subway tile installation (Additional per 1st proposal) $760	760.00	(260.00)	500.00
Install 18 sf kitchen backsplash ($ 90.00)	90.00	-	90.00
Install kitchen cabinets ONLY ($ 1,200.00)	1,200.00	(1,200.00)	-
Remove wonderboard in presidential bathroom shim and reinstall tape (For shower led) ($ 300.00)	300.00	-	300.00
Install 132SF wood floor in conference room (Installation ONLY) ($ 2,985.00)	2,985.00	-	2,985.00
Install 265SF wood floor in presidential room (Installation ONLY)			
Patch ceilings after plumbing and electric trades finish ($ 300.00)	300.00	(150.00)	150.00
Open 2 small bathrooms install plywood blocking patch, and spakle ($ 300.00)	300.00	(150.00)	150.00
Path basement ceiling corners from wall to ceiling ($ 300.00)	300.00	(150.00)	150.00
box with pine around basement door to cover cables ($ 300.00)	300.00	(150.00)	150.00
Prehung,cut as required and install wood doors after finish floor ($ 600.00)	600.00	(300.00)	300.00
Install 560 LF ofbase molding (Installation only) ($ 1,500.00)	1,500.00	(300.00)	1,200.00
Complete protection for finish flooring ($ 1,900.00)	1,900.00	(500.00)	1,300.00
Square 2 doors openings , install new corner beats and spakle ($ 300.00)	300.00	(250.00)	150.00
Patch and seal roof with flashing cement ($ 50.00)	50.00	-	50.00
Deliver material to site ($ 300.00	300.00	(300.00)	-
Overhead	3,338.00	(3,338.00)	-
	25,593.00	**(9,948.00)**	**15,645.00**

EXTRAS #2 - Proposal dated 10/29/2019

Scope-	Orlginal Amount	Adjustments	Final Amount
Digout basement dirt and install drain. Complete and installe tiles ($ 2,100.00)	2,100.00	-	2,100.00
Change color in office &hallways ($ 7,000.00)	7,000.00	(4,500.00)	2,500.00
Create saddle in conference room and complete flooring to wall / cure wood floor ($ 700.00)	700.00	(200.00)	500.00
Create templates / install window seales ($ 900.00)	900.00	-	900.00
Stucco wall in bathroom ($ 300.00)	300.00	-	300.00
Level doors after floor guys damage them ($ 600.00)	600.00	(600.00)	-
Furnish and install FRP panels in garage ($ 800.00)	800.00	-	800.00
Create and install wood saddle from garage to office ($ 150.00)	150.00	-	150.00
Cut & install metal kickplates ($ 150.00)	150.00	-	150.00
Install all bathroom fixtures ($ 900.00)	900.00	(900.00)	-
Create template / install kitchen countertop with sink $500	500.00	-	500.00
4 Additional boxes of subway tile for kitchen backsplash ($ 240.00)	240.00	(240.00)	-
Provide grout for bathrooms ($ 500.00)	500.00	(250.00)	250.00
Patch damage from hvac/electricion,it , plumbing ($ 900.00)	900.00	(250.00)	750.00
Demo self level to install toilet flentch ($ 150.00)	150.00	-	150.00
Additional access door in electrical room closet ($ 150.00)	150.00	-	150.00
Metal ladder to access closet ($ 1,200.00)	1,200.00	-	1,200.00
Install door 2 adjustables closer ($ 200.00)	200.00	-	200.00
Sand,stain, polyurethane on Wood roller for david office ($ 200.00)	200.00	-	200.00
Install board in hallways ($ 200.00)	200.00	(100.00)	100.00
Match and paint stucco wall in conference room. ($ 600.00)	600.00	-	600.00
patch ceiling around recessed light			
One more coat on walls ,ceiling			
Additional coat for hallway ($ 900.00)			
Metal strip in garage double door closure ($ 90.00)	900.00	(250.00)	750.00
Furnish and install weather strip in backyard door ($ 250.00)	90.00	-	90.00
Install 2 floor cylinder lock ($ 200.00)	250.00	-	250.00
Glass for table ($ 400.00)	200.00	-	200.00
Overhead	400.00	(400.00)	-
	3,072.00	(3,072.00)	-
	23,552.00	**(10,762.00)**	**12,790.00**

Gmail

JORGE IVAN MOSCOSO <jimassociatescorp@gmail.com>

Stucco wall invoice

1 message

JORGE IVAN MOSCOSO <jimassociatescorp@gmail.com> Tue, Sep 3, 2019 at 3:34 PM
To: David Kleeman <Dkleeman@askelectric.com>

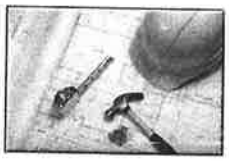
--
Regards,

Jorge Moscoso - President

JIM ASSOCIATES CORP.

JIM ASSOCIATES CORP.
21-57 42TH STREET
ASTORIA, NY 11105
Tel:646-296-7757
jimassociatescorp@gmail.com

Ask stucco wall - Ask invoice.pdf
684K



INVOICE

JIM ASSOCIATES CORP.
21-57 42TH STREET BSMNT
ASTORIA,NY 11105
jimassociatescorp@gmail.com

DATE:	**September 3, 2019**
PREPARED BY:	Moscoso Jorge
CONTRACT / P.O. #	

CUSTOMER:	Ask
PROJECT NAME:	Stucco walls
ADDRESS:	217-14 Hempstead Av Jamaica,NY 11429
CONTACT:	

Jim Associates Corp. proposes to provide all necessary labor, materials, tools, and equipment to complete :the renovation at above referenced project as per site survey and/or specifications for the following prices

Description	Amount
Scope-	
Stucco conference room -	$ 2,200.00
SUBTOTAL	$ 2,200.00
	$ 2,200.00

We hereby accept the conditions of this proposal: You are authorized to commence work.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chair, Workers' Compensation Board at the address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2 or EC-2, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your insurance carrier.**

THE STATE INSURANCE FUND, 199 CHURCH ST, NEW YORK, NY 10007-1100

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS				
1. W.C.B. Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Claimant's Soc. Sec. No.
G2580210	72134075-373	W204002	06/28/2019	0

NAME		Address to which notice should be sent (Give Number and Street, City, State, and Zip Code)	
6. Injured Person	REYESESPINOZA STALIN	151 AVE O 3B, BROOKLYN NY 11204	Apt No.
7. Employer	JIM ASSOCIATES CORP.	21-57 42 STREET, ASTORIA, NY 11105	
8. Carrier	THE STATE INSURANCE FUND	199 CHURCH ST, NEW YORK, NY 10007-1100	

9. Date of most recent Employer's Report filed: (check "x" and give date filed) ☐ C-2/EC-2 _____ ☐ C-11/EC-11 _____

10. Date of first full day employee lost from work: _____ 11. Nature of Injury: _____

12. Date employee returned to work: HAS NOT RETURNED TO WORK - WE LOST CONTACT.

13. (a) Change of employment status resulting from above injury:

Employment Status	Hours per Day	Days per Week	Earnings per Week	Occupation
Prior To Injury				
Changed To				

(b) Date of this change in employment status: _____

(c) Remarks: _____

14. Loss of time resulting from above injury since first return to work: He'd not return to work.

From (mm/dd/yyyy)	To (mm/dd/yyyy)	Reason

15. Is injured person still under physician's care? DON'T KNOW If yes, give name of physician: _____

16. Has injured person died? NO If yes, give date of death: _____

Name and address of nearest known relative: _____

Date of this report 8/7/19 Tel. No. 347-863-9344 Firm Name _____

Prepared By: Freddy Perez Official Title Vice President of JIM ASSOCIATES

CM: Nica Bradshaw

00000000000072381516

Form C-11 Version 1 (11/26/2013) [WC Loss ID-72134075]

www.wcb.ny.gov

C-11 (1-11) C-11 C-11 C-11 C-11

NEW YORK STATE Workers' Compensation Board

EMPLOYER'S STATEMENT OF WAGE EARNINGS (Preceding the Date of Injury/Illness)

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: 06/28/2019 WCB Case #: G2580210 Claim Administrator Claim (Carrier Case) #: 72134075

Injured Worker Information

Last Name: Reyesespinoza First Name: Stalin MI:

Mailing Address: 151 Ave O Line 2:

City: BROOKLYN State: NY Zip Code: 11204

Job Title: WORKING ON THE FIELD Social Security #: 0

Insurer Information

Insurer Name: NEW YORK STATE INSURANCE FUND Insurer ID (W#): 204002

Mailing Address: 199 CHURCH ST Line 2:

City: NEW YORK State: NY Zip Code: 10007-1100

Insurer Phone #: (212)587-6568 Insurer Fax #: (212)312-0043 Email Address:

Employer Information

Employer Name: JIM ASSOCIATES CORP.

Mailing Address: 21-57 42 STREET Line 2:

City: ASTORIA State: NY Zip Code: 11105

Employer Phone #: 6462967757 Federal Tax ID #: 46-4457133 The Tax ID # is the (check one): ☐ SSN ☐ EIN

To determine Average Weekly Wage (AWW), the Board needs the gross weekly earnings for the 52 weekly periods immediately preceding the date of the injury/illness. This information can be provided by 1) attaching detailed payroll information that indicates days paid and gross weekly earnings; 2) if injured worker is paid by salary and his or her weekly pay does not change from week-to-week, attach document(s) providing their salary information for the previous 52 weeks; or 3) by completing and submitting the **Injured Worker Payroll** section on page 2 of this form.

If the injured worker has not worked at the same employment for one year or a substantial part of the year, also attach detailed payroll information for an employee of the same class, or complete and submit the **Employee of the Same Class Payroll** section on page 2 of this form. "Substantial part of the year" does not require any particular number of days worked but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

1. Payroll information is: ☑ attached ☐ completed on page 2

2. Did the injured worker's compensation include board, rent, housing, tips and/or gratuities, in addition to gross weekly earnings? ☐ Yes ☑ No

If Yes, what was the weekly value:

Nature of the compensation:

3. Basis for the injured worker pay rate is: ☑ hourly ☐ daily ☐ weekly ☐ monthly ☐ annually

4. The injured worker works a: ☑ 5 ☐ 6 ☐ 7 ☐ Other day week. If Other, Explain:

5. Total days paid in the preceding 52 weeks: 45 6. Total gross amount paid including overtime in the preceding 52 weeks: 6480

7. Was there any wage adjustment made that affected the 52-week period? (If injured worker was in military service, please indicate and provide date of discharge.) ☐ Yes ☐ No

If "Yes", explain:

8. Was the injured worker laid off during the preceding 52 weeks? ☐ Yes ☑ No

If Yes, provide dates of layoff :

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Prepared By - The above information is true and to the best of my knowledge and belief.

Last Name: Perez First Name: Freddy MI:

Employer Name: Stalin Reyes Espinoza

Official Title: Vice-President Daytime Phone #: 347-963-4344

Email Address: FreddyPx1@Gmail.com Date of this Report: 8/07/19

0000000000802581516

Injured Worker's Name: Stalin Reyesespinoza Date of Injury/Illness: 06/28/2019 WCB Case #: G2580210

INJURED WORKER PAYROLL Enter the injured worker's gross weekly earnings for the 52 weekly periods immediately preceding the date of injury/illness. In the "**Days Paid**" column enter the number of days compensated, including paid time off.

Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime	Week No.	Week Ending Date	Days Paid	Gross amount paid including overtime
1				19				37			
2				20				38			
3				21				39			
4				22				40			
5				23				41			
6				24				42			
7				25				43			
8				26				44	5/3/19	5	720
9				27				45	5/10/19	5	720
10				28				46	5/17/19	5	720
11				29				47	5/24/19	5	720
12				30				48	5/31/19	5	720
13				31				49	6/7/19	5	720
14				32				50	6/14/19	5	720
15				33				51	6/21/19	5	720
16				34				52	6/28/19	5	720
17				35				Total:		5	6480
18				36							

EMPLOYEE OF THE SAME CLASS PAYROLL If the injured worker has not worked at the same employment for one year or a substantial part of the year, enter the gross weekly earnings for an employee of the same class. "Substantial part of the year" does not require any particular number of days worked, but as a guideline 234 days at 5 days per week and 270 days at 6 days per week.

Employee of the Same Class

First Name: JORGE MOLCOMO Last Name: MOLCOMO MI:

Job Title: Plaster (Painter (Journ)

Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime	Week No.	Week Ending Date	Days Paid	Gross Amount Paid including Overtime
1	1/4/19	5	540	19	5/10	5	750	37	9/13		—
2	1/11/19	5	540	20	5/17	5	750	38	9/20		—
3	1/18/19	5	540	21	5/24	5	750	39	9/27		—
4	1/25/19	5	540	22	5/31	5	750	40	10/4		—
5	2/1/19	5	540	23	6/7	5	750	41	10/11		—
6	2/8/19	5	540	24	6/14	5	750	42	10/18		—
7	2/15/19	5	540	25	6/21	5	750	43	10/25		—
8	2/22/19	5	540	26	6/28	5	750	44	11/1		—
9	3/1/19	5	540	27	7/5	5	750	45	11/8		—
10	3/8/19	5	540	28	7/12	5	750	46	11/15		—
11	3/15/19	5	540	29	7/19	5	750	47	11/22		—
12	3/22/19	5	540	30	7/26	5	750	48	11/29		—
13	3/29/19	5	540	31	8/2	5	750	49			
14	4/5/19	5	750	32	8/9	5	750	50			
15	4/12/19	5	750	33	8/16		750	51			
16	4/19/19	5	750	34	8/23		—	52			
17	4/26/19	5	750	35	8/30		—	Total:			
18	5/3/19	5	750	36	9/6		—				

JIM ASSOCIATES CORP
2157 42ND STREET BSMT | ASTORIA, NY 11105
EIN: 46-4454278

Payroll Register

May 1 - Jun 30, 2019

Employee		Check Info				Payroll Details										
Name	SSN	Pay Start	Pay End	Chk Date	Chk #	Hours	Gross	Fed W/H	Soc Sec	Med Care	Med Care Addl	State W/H	SDI	Other Tax	Local Tax	Net Pay
STALIN REYES-ESPINOZA	000-00-0000	04/27/19	05/03/19	05/03/19	10255	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		05/04/19	05/10/19	05/10/19	10256	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		05/11/19	05/17/19	05/17/19	10257	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		05/18/19	05/24/19	05/24/19	10258	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		05/25/19	05/31/19	05/31/19	10259	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		06/01/19	06/07/19	06/07/19	10260	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		06/08/19	06/14/19	06/14/19	10261	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		06/15/19	06/21/19	06/21/19	10262	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
		06/22/19	06/28/19	06/28/19	10263	40.00	720.00	-64.00	-44.64	-10.44	-	-29.16	-0.60	-1.10	-21.41	548.65
					Totals	360.00	6,480.00	-576.00	-401.76	-93.96	-	-262.44	-5.40	-9.90	-192.69	4,937.85